COASTAL FAMILY
DERMATOLOGY

ADULT HISTORY FORM

Name:_____ Date of Birth:___/___/_____
Race:_____ Ethnicity:_____ Preferred Language:_____

Medication Allergies? None Known ____ Please List:_____
_____

Preferred Pharmacy (Name, Address, Phone Number):
_____

Medication	**Dose (mg)**	**Frequency (#/day)**

Past Medical History - Do you have now, or have you ever had diseases or conditions of (please circle all that apply):

NONE
Anxiety/Depression
Arthritis (osteo, RA, other)
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Cancer (Type_____)
COPD
Coronary Artery Disease
Diabetes
Kidney Trouble (Type_____)
Heartburn (GERD)
Hearing Loss
Hepatitis (Type_____)
High Blood Pressure
High Cholesterol
Immune **Compromised:**
__HIV __Organ Transplant
Thyroid Problems
Lymphoma
Radiation Treatment
Seizures
Stroke

Other:_____

Past Surgical procedures or Hospitalizations (please circle all that apply):

NONE
Appendix Removed
Mastectomy / Lumpectomy / Breast biopsy
Breast Reduction / Implants
Colectomy: Colon Cancer Resection / Diverticulitis / IBD
Gallbladder Removed
Coronary Artery Bypass
(Heart Valve Replacement - **Mechanical / Biological**)
Hysterectomy / Ovaries Removed:
Endometreosis / Cyst / Cancer
Joint Replacement: Knee / Hip
- Within past 2 years? **Y / N**
Organ Transplant:_____
Prostate Removed: Prostate Cancer
Spleen Removed

Other:_____

Social History (please circle applicable answers):

Do you smoke / use tobacco?	**Y / N**	Never / Currently / Formerly- Year quit_____
Do you drink alcohol?	**Y / N**	None / <1-2 drinks/day / >3 drinks/day
Do you wear sunscreen?	**Y / N**	If yes, what SPF?_____
Do you tan in a tanning salon?	**Y / N**	
Do you have a family history of Melanoma?	**Y / N**	If yes, which relative(s)?_____

Other:_____

Skin Disease History (please circle all that apply):

NONE
Acne
Precancerous skin lesions (Actinic Keratosis)
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Dysplastic or Atypical Moles
Easy Bruising/Bleeding
Eczema
Flaking or Itchy Scalp
Melanoma - Y/N if yes, please list year:_____
Metal allergy
Poison Ivy
Poor/slow healing
Psoriasis
Rash to medication or food
Scars/Keloids
Squamous Cell Skin Cancer

Other:_____

Alerts (please circle all that apply):

Allergy to Adhesive/Lidocaine/Topical Antibiotics
Blood Thinners
Defibrillator/Pacemaker
MRSA
Require antibiotics prior to surgical procedures
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant? Y/N

Coastal Family Dermatology

Patient Personal Information:

NAME:_____DOB:_____SEX:____M___F____

SSN:_____MARITAL STATUS (CIRCLE ONE):SINGLE/MARRIED/DIVORCED/WIDOWED

PRIMARY ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____EMAIL:_____

PHONE:_____WORK:_____CELL:_____

EMERGENCY
CONTACT:_____RELATIONSHIP:_____PHONE:_____

EMPLOYMENT STATUS: EMPLOYED NOT EMPLOYED RETIRED STUDENT

EMPLOYER:_____OCCUPATION/SCHOOL:_____

PHYSICIAN INFORMATION:

REFERRING PHYSICIAN:_____PHONE:_____

PRIMARY CARE PHYSICIAN:_____PHONE:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____ID#_____GROUP#_____

SUSCRIBER NAME:_____DOB:_____RELATIONSHIP:_____

SECONDARY INSURANCE:_____ ID#_____GROUP#_____

SUSCRIBER NAME:_____DOB:_____RELATIONSHIP:_____

PATIENT CONSENT (*PLEASE INITIAL EACH SECTION*)

_____ ePrescribing is a physician's ability to electronically send accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physicians and/or staff of Coastal Family Dermatology to enroll me in the ePrescribe program.

_____ I authorize the physicians and or staff of Coastal Family Dermatology to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager, and/or any third party pharmacy payors for treatment purposes.

_____ if a patient requires an accommodation for their appointment, the individual and/or his/her representative must notify Coastal Family Dermatology of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American's with Disabilities Act, "providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge on to the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by Coastal Family Dermatology are the patient's responsibility.

_____ I allow the physician's and/or staff of Coastal Family Dermatology to photograph me or my minor child for medical purposes.

_____ I allow Coastal Family Dermatology to use my photo or the photograph of my minor to be used for teaching/instructional purposes.

_____ I want to communicate via email with Coastal Family Dermatology on matters of my and/or my child's medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice or any of the workforce members liable for the loss of any confidentiality associated with such transmissions.

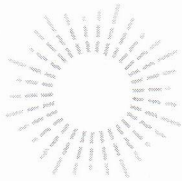
_____ Coastal Family Dermatology has a secure patient portal which allows communication between the practice and you, the patient. It is our policy to request your email address to activate your secure portal. Once we receive your email address you will be enabled, giving you a username and password to access your patient information, through this system you will be able to complete your patient paperwork, schedule appointments, request medical refills, request referrals, receive medical record information and communicate on non-emergent issues with the office.

_____ I give the physicians and office staff of Coastal Family Dermatology permission to discuss my financial status and any medical condition concerning myself and/or my child with the following individuals.

NAME:_____RELATIONSHIP_____

NAME:_____REALTIONSHIP_____

PATIENT SIGNATURE:_____DATE:_____



Financial Policy and Conditions of Treatment

Coastal Family Dermatology is committed to the success of your medical and aesthetic treatment and care. Our practice will work with you to help fulfill your payment responsibility. We will file your primary and secondary medical claims for you. It is imperative that you provide us with current and accurate insurance information at the time of your appointment.

Insurance information is required at the time of your visit. You have final responsibility for payment of services provided. Your participation in the process is both essential and encouraged. Thank you for allowing Coastal Family Dermatology to be your healthcare provider.

If you fail to provide insurance information, you will be considered Self Pay and will be required to pay in full at the time of your service. It is important for you to understand that you have a contract with your insurance carrier and will need to help us work with your insurance carrier to expedite the reimbursement process.

Privacy Policy: As required by law, Coastal Family Dermatology maintains a privacy policy dedicated to the protection of our patient's medical information. A copy of this is posted in the office for your review.

Medicare: Coastal Family Dermatology is a participating Medicare provider, accepting assignment for Medicare Part B (Physician Serviced) claims. **The patient is responsible for their Medicare co-insurance, deductibles and any services rendered that are not covered by Medicare.**

CenCal: Coastal Family Dermatology accepts CenCal patients with a valid authorization submitted by the Primary Care Physician (PCP). CenCal patients must submit a **VALID** identification card at every visit. The patient is responsible for any spend down amount for services provided on dates that are not eligible for coverage. The patient is responsible for any services rendered that are not covered by CenCal.

Medi-Cal: Coastal Family Dermatology is not currently contracted as a Medi-Cal only provider.

Managed Care Plans: In order to see a specialist, some insurance plans require a referral from the Primary Care Physician (PCP) or pre-certification PRIOR to the visit. It is the **patient's responsibility** to ensure we have this referral or pre-certification **prior** to the visit. If we do not receive the necessary referral or pre-certification, the patient will be responsible for payment or will need to reschedule their appointment. **ALL CO-PAYS ARE DUE AT TIME OF SERVICE**.

Commercial Plans: Coastal Family Dermatology has established fees that are usual and customary for this healthcare service area. Every insurance carrier has their own usual and customary fee schedule; however, the patient will be responsible for payment regardless of the insurance carrier's arbitrary determination of rates. **As the patient, you are responsible for any unpaid balance not contractually**

covered by your insurance. As the patient, you are responsible for understanding your covered benefits for your insurance plan. ALL CO-PAYS ARE DUE AT TIME OF SERVICE.

Non-Covered Services: some services we provide may be deemed not medically necessary by your insurance carrier or not a covered benefit by your specific policy, therefore, not paid by your insurance. Many cosmetic procedures we provide are not covered by insurance. This may include treatment of benign normal skin changes or growths, such as but not limited to, skin tags, cysts, age spots, etc. the patient is responsible for payment at the time of service for all services not covered by insurance.

Laboratory Services: Some services, such as but not limited to biopsies or surgery, require that specimens be sent to a laboratory for processing. We currently use WDSL (Western Diagnostic Services Laboratory) for our laboratory services. The patient may receive a separate bill from the laboratory. The patient is responsible for payment for all laboratory services not covered by insurance.

Self-Pay: Patients who do not have insurance coverage are considered self-pay. Self-pay patients will be required to pay in full **prior to services** being rendered.

Payment Arrangements: Coastal Family Dermatology may consider payment arrangements for those patients who need assistance in meeting their account obligation. Coastal Family Dermatology reserves the right to set the terms, conditions and to charge interest for any payment not made it full at the time of service.

Credit Cards: Coastal Family Dermatology accepts credit card payment via Square and Stripe. We also accept debit cards, checks and cash. **We request patients leave a credit card on file, after sending two (2) statements, if balance is not cleared, Coastal Family Dermatology will charge the card the balance in lieu of turning over to a collection agency.**

Returned Check Policy: Coastal Family Dermatology will charge a **twenty-five dollar ($25.00)** fee for each check returned by our bank for non-sufficient funds. As a courtesy, we will attempt to submit a check to our bank one additional time should the check be returned from the initial deposit.

Disability/ FMLA/ Other Forms: Coastal Family Dermatology may charge a **twenty dollar ($20.00)** fee for the completion of each form. Multiple forms are $20.00 for each form. **Payment is required prior to the completion of any form.**

Missed Appointment Fees: Coastal Family Dermatology may charge a fee for missed office visit appointments when the patient fails to give appropriate notification. **A cancellation notice must be received twenty-four (24) hours or one full business day before the scheduled appointment. A ninety-five-dollar ($95.00) charge may be applied (at the discretion of Coastal Family Dermatology) for failure to meet this requirement. Cosmetic and surgical appointments must be cancelled seventy-two (72) hours or three (3) full business days in advance or a two-hundred and fifty ($250.00) charge may be applied.**

Late Fees: Coastal Family Dermatology may charge a **seven-dollar and fifty cent ($7.50)** monthly billing fee for delinquent accounts considered to be past due.

Interest Fees: Coastal Family Dermatology reserves the right to charge a monthly interest fee as defined by state law for delinquent accounts considered to be past due.

Collection Agencies: Should it become necessary for Coastal Family Dermatology to send a patient's account to a collection agency, the patient will be responsible for any and all fees associated with the collection effort of the account, to include reasonable attorney fees, court costs, collection charges and interest.

Business Office Contact: Coastal Family Dermatology's business office can be reached at 805.544.4467. please do not hesitate to contact the business office during regular hours if you have a question.

PATENT ACKNOWLEDGEMENT and AUTHORIZATIONS:

Authorization for Treatment: With your signature below, Coastal Family Dermatology is hereby authorized to conduct examination, perform procedures as are medically required and administer treatment and medications as deemed necessary or advisable.

Authorization for Release of Information: With your signature below, Coastal Family Dermatology is hereby authorized to release a complete report of services rendered, diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billings agents, insurance carriers, employer's workers compensation insurance company, other third-party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other intermediaries responsible for payment for services rendered. The release of information consent may be revoked at any time by giving written notice. If release of information is refused, the patient will be held responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits: In consideration of medical services provided, with your signature below, Coastal Family Dermatology, (and the laboratory in the case of laboratory services) is given all rights, title and interest to the medical reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefit including Medicare Part B. The patient will be fully responsible for payment of any and all charges not covered by insurance.

I have read this Financial Policy and Authorizations. I understand that there is no guarantee or assurance as to the results that may be obtained from any treatment. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient/Responsible Party Signature _____ ***Date*** _____

Patient's Printed Name _____ DOB_____

Witness Signature_____ ***Date***_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission as to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides by judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rate share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within the arbitration agreement, including, but not limited to Code of Civil Procedures Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be bared by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency treatment) patient should initial below.

Effective as of the date of first medical services

_____
Patient or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT

By: _____
Patient's Signature Date

_____
Print Patient's Name

By: _____
Patient's Representative's Signature Date

_____

Christine D. Kilcline, MD

By: _____
Date

A signed copy of the document is to be given to the Patient. Original is to be filed in Patient's medical records

Open Payments Database

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Medical Board of California

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov,
email: licensecheck@mbc.ca.gov,
or call (800) 633-2322.

Aviso A Los Pacientes

Los medicos estan autorizados y regulados por la junta medica de California. Para verificar una licencia o presentar una queja, visite www.mbc.ca.gov

Correo electronico: licensecheck@mbc.ca.gov,
or call (800) 633-2322.

PATIENT PARTICIPATION PACKET

This medical office is partnering with our electronic health record (EHR) company to develop an artificial intelligence powered tool, with the goal of making it easier and more efficient for doctors to prepare their chart notes. We are asking for your consent to participate in the development of this tool by allowing us to record the **audio** of your health care visit with your provider. If you participate, the audio of the visit will be recorded through our EHR company's software as described on the next two pages. To help you better understand this program, here are some answers to Frequently Asked Questions.

What do I need to do if I want to participate?
To provide consent, you will sign the next two pages of this packet. The first page is a consent allowing our EHR company (Modernizing Medicine, Inc., known as ModMed) to use the audio recording and its content for technology development. The second page is an authorization specifically related to the use of your health information. Your doctor will also ask you verbally for consent before turning on the audio recorder during any given visit.

What will be recorded?
We will be recording the audio or verbal conversation with your doctors and other health care personnel at this office. We will not be recording any video.

If I agree to participate, will all of my future doctor visits be recorded automatically?
No. You have the option at each visit with our office to tell the provider if you are comfortable with that visit being recorded. Your provider will ask you for your permission before turning on the recorder at any visit. In addition, some providers at our office may decide not to record certain visits.

What will my recordings be used for?
The recordings will be used for developing the artificial intelligence powered tool designed to help physicians more effectively document their visits with patients.

Who will listen to my recordings?
In general, no one will listen to your recordings. The recording content will be used to inform and develop the artificial intelligence technology and computer algorithms designed to help improve clinical documentation. There may be times when a ModMed employee or contractor needs to listen to your recording for troubleshooting or other development purposes.

Will my recordings be kept forever?
No, the recordings will be deleted six months after the visit. ModMed may keep a written transcript of the recording for longer. If so, ModMed will use technology designed to remove content from the transcript that may identify you or your provider.

Can I change my mind after signing the consent?
Yes, you can revoke your consent by emailing mmaiscribe@modmed.com or you can tell your provider not to record a particular visit.

Does participating affect the quality of care I receive?
No, you will receive the same quality of care regardless of whether you participate, and your participation is entirely voluntary.

Are there any benefits to me participating?
There are no tangible benefits to you participating. However, you may enjoy intangible benefits knowing that you helped contribute to improving health care technology and making it easier for doctors to document their visits with patients, which could ultimately help improve patient care.

What if a friend or family member is with me at an appointment?
Any visitors with you at an appointment that is being recorded should sign the first consent form in this packet. Please notify the front desk if your friend or family member has not signed this form. (Visitors do not need to sign the second consent form, which is specifically about the health care information that is discussed.)

RELEASE FOR PROVIDER INTERACTION CONTENT

For the intangible value gained from participation in the improvement of health care technology and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, I (or a third party authorized to act on my behalf) ("**Participant**") hereby grant to Modernizing Medicine, Inc., a Florida for-profit corporation, and its affiliates, subsidiaries, licensees, agents, successors, designees, and assigns (collectively, "**Company**") the right to use Participant's name, likeness, voice, conversation, sounds, and/or material (collectively, my "**Appearance**") as follows:

1. Participant agrees that Company shall have the right to create and capture audio-only works, including recordings of and from Participant's Appearance and interactions with health care providers and/or patients (the "**Content**") by any method of recording without further consent from or any royalty, payment, or other compensation to Participant.
2. Participant acknowledges and agrees that for each health care visit between Participant and a health care provider and/or patient (each visit, a "**Provider Interaction**"), the Content includes: (a) an audio recording of the Provider Interaction, with such audio recording to be retained by Company for a period not to exceed six months, (b) a transcript of such audio recording, with such transcript to be retained by Company for a period not to exceed six months, and (c) a modified transcript of the audio recording that has been processed using third-party technology and/or tools designed to remove content from the transcript that would identify the patient, health care provider, and/or Participant. Company will retain such modified transcript for as long as the Company so chooses.
3. Participant agrees that Company shall forever own all rights, including copyright, in the Content and the results and proceeds of such Content, and shall have the irrevocable right to use, and license others to use, the Content in whole or in part, an unlimited number of times, in all languages, in all media whether now known or hereafter devised, anywhere in the universe in connection with the development and improvement of Company technology that may be used to help improve clinical documentation and physician practice management, including without limitation, distribution of the Content to any and all persons present at a Provider Interaction, anyone employed by or affiliated with Company who listens to the recording of the Provider Interaction after it is recorded or reviews a transcript of the recording, and anyone the Company may hire or contract with to capture, transcribe, edit or de-identify the recording or assist in the development of the Company products. Company shall have the right to edit the Content in any manner or form. Participant hereby waives any right of inspection or approval of Participant's Appearance, including any Content related to Participant's Appearance.
4. Participant hereby releases, discharges, and holds harmless Company from all claims, demands, or causes of action that Participant may have or receive from a third party, including without limitation, claims based upon defamation, invasion of privacy, rights of publicity, commercial disparagement, or any other claims arising from the creation of or use of the Content or Participant's Appearance.
5. Company is not obligated to actually use Participant's Appearance or the Content.
6. This Appearance Release shall be governed by the laws of the State of Florida (excluding its conflicts of law principles), regardless of the place of its physical execution and shall be binding on me and my successors, parents, licensees, legal representatives, heirs, and assigns (as applicable). Participant hereby submits to the jurisdiction of the state and federal courts of Palm Beach County, Florida, to resolve any dispute arising out of or resulting from this Appearance Release. Participant shall not raise, and hereby waives, any defenses based upon improper venue, inconvenience of the forum, lack of personal jurisdiction, or the sufficiency of service of process. Termination of this Appearance Release, for any reason, shall not affect Company's rights in the Content. Company may assign its rights in the Content, in whole or in part, to any individual or entity, without restriction.
7. This Appearance Release represents the entire understanding and supersedes all prior understandings between the parties relating to the subject matter herein.

AGREED AND ACCEPTED

Participant Name: _____

Signature: _____ Date: _____

Authorization for Use and Disclosure of Protected Health Information for Recording

Patient Name: _____ Date: _____

By signing this form, I authorize my physician or other provider ("Provider") to record the audio of my interactions with the Provider using the recording tool provided by Modernizing Medicine, Inc. (the "Company"). I understand that the Company will record and access such recordings for purposes of the development and improvement of Company technology that may be used to help improve clinical documentation and physician practice management.

Information to be Used and Disclosed: All audio information heard or recorded in connection with or during my interaction(s) or visit(s) with my Provider from October 1, 2023 through December 31, 2024 ("Provider Interactions"), including without limitation, conversations, sounds, audiotapes, and/or verbal statements made during the Provider Interactions by anyone present, and my demographic, biographical, and medical information (including any and all clinical documentation) related to such Provider Interactions.

Persons Authorized to Receive Information: (1) Any and all persons present at the Provider Interactions, (2) anyone employed by or affiliated with Company who, for purposes of development and improvement of Company technology, listens to the recording of the Provider Interaction after it is recorded or reviews a transcript of the recording or associated clinical documentation, and (3) anyone the Company may hire or contract with to capture, transcribe, edit, aggregate, or modify the recording or transcript or to assist in development of the product(s).

Purposes: For development and improvement of Company technology that may be used to help improve clinical documentation and physician practice management. I understand and agree that Company will store my information in its audio-recorded format for a maximum period of six (6) months. I further understand and agree that Company will create a transcript of the recording to be retained for a maximum period of six (6) months from the date of the Provider Interaction that was recorded. I understand and agree that no later than six (6) months after the date of the recorded Provider Interaction, the Company will destroy the recording and will use third-party technology and/or tools designed to remove content from the transcript that may identify me and that Company will retain such modified transcript for as long as the Company so chooses.

Right to Revoke: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting an email to Company at mmaiscribe@modmed.com, or (if revoking during the Provider Interaction), by informing my provider. Unless revoked, this authorization will expire on December 31, 2024. After expiration or revocation of this authorization, the Company may continue to use and disclose any modified transcripts created from Provider Interactions that occurred before I revoked consent. The Company may destroy or dispose of recordings and transcripts at any time without notice to me.

Re-disclosure/Voluntary Consent. I understand the information disclosed by this authorization may be subject to re-disclosure by anyone receiving it, and the information disclosed will no longer be protected by federal privacy laws and regulations. This authorization is voluntary. I understand that neither the Company nor my provider may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization form.

_____ _____

Signature of Patient or Representative Date

_____

Description of Representative's authority to act on behalf of Patient, if applicable